

		FOR OHF USE					

LL 1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0010561</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Knox County Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/03</u> to <u>11/30/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>800 North Market Street</u> <u>Knoxville</u> <u>61448</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Knox</u>			
Telephone Number: <u>(309) 289-2338</u> Fax # <u>(309) 289-8384</u>			
IDPA ID Number: <u>376001167801</u>			
Date of Initial License for Current Owners: <u>10/23/1946</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 384-6000</u> Please send copies of desk review and audit adjustments to address on this page		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # (312) 634-5518	
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home# 0010561 Report Period Beginning: 12/01/03 Ending: 11/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>204</u>	Skilled (SNF)	<u>204</u>	<u>74,664</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>204</u>	TOTALS	<u>204</u>	<u>74,664</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,493</u>	<u>3,580</u>	<u>3,289</u>	<u>17,362</u>	8
9	SNF/PED					9
10	ICF	<u>28,816</u>	<u>11,351</u>	<u>580</u>	<u>40,747</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,309</u>	<u>14,931</u>	<u>3,869</u>	<u>58,109</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.83%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/28/1966

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date N/ANO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 26 and days of care provided 3,289Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 11/30/04 Fiscal Year: 11/30/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/03 Ending: 11/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	378,168	33,571	8,190	419,929		419,929		419,929			1
2	Food Purchase		376,377		376,377		376,377	(33,530)	342,847			2
3	Housekeeping	218,651	39,774		258,425		258,425		258,425			3
4	Laundry	69,248	15,933	117,024	202,205		202,205		202,205			4
5	Heat and Other Utilities			212,584	212,584		212,584		212,584			5
6	Maintenance	125,587	49	180,523	306,159		306,159		306,159			6
7	Other (specify):*											7
8	TOTAL General Services	791,654	465,704	518,321	1,775,679		1,775,679	(33,530)	1,742,149			8
	B. Health Care and Programs											
9	Medical Director			12,500	12,500		12,500		12,500			9
10	Nursing and Medical Records	3,059,477	199,784	31,754	3,291,015		3,291,015	(1,112)	3,289,903			10
10a	Therapy			122,952	122,952		122,952		122,952			10a
11	Activities	95,650	6,791	2,353	104,794		104,794		104,794			11
12	Social Services	153,115	1,496	2,352	156,963		156,963		156,963			12
13	Nurse Aide Training											13
14	Program Transportation	18,433			18,433		18,433		18,433			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,326,675	208,071	171,911	3,706,657		3,706,657	(1,112)	3,705,545			16
	C. General Administration											
17	Administrative	91,177		10,200	101,377		101,377		101,377			17
18	Directors Fees			2,065	2,065		2,065		2,065			18
19	Professional Services			35,692	35,692		35,692		35,692			19
20	Dues, Fees, Subscriptions & Promotions			21,232	21,232		21,232		21,232			20
21	Clerical & General Office Expenses	159,393	11,707	26,648	197,748		197,748	14,858	212,606			21
22	Employee Benefits & Payroll Taxes			754,976	754,976		754,976	642,174	1,397,150			22
23	Inservice Training & Education			4,862	4,862		4,862		4,862			23
24	Travel and Seminar			1,454	1,454		1,454		1,454			24
25	Other Admin. Staff Transportation			7,166	7,166		7,166		7,166			25
26	Insurance-Prop.Liab.Malpractice			12,356	12,356		12,356		12,356			26
27	Other (specify):*											27
28	TOTAL General Administration	250,570	11,707	876,651	1,138,928		1,138,928	657,032	1,795,960			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,368,899	685,482	1,566,883	6,621,264		6,621,264	622,390	7,243,654			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Knox County Nursing Home

#0010561

Report Period Beginning:

12/01/03

Ending:

11/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			151,200	151,200		151,200	15,409	166,609			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,780	2,780		2,780	(2,780)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,911	2,911		2,911		2,911			35
36	Other (specify):*											36
37	TOTAL Ownership			156,891	156,891		156,891	12,629	169,520			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	40,921	273,449	9,866	324,236		324,236		324,236			39
40	Barber and Beauty Shops	18,384	1,172		19,556		19,556	(1,172)	18,384			40
41	Coffee and Gift Shops			8,834	8,834		8,834		8,834			41
42	Provider Participation Fee			111,888	111,888		111,888		111,888			42
43	Other (specify):* Nonallowable Costs			120,047	120,047		120,047	(120,047)				43
44	TOTAL Special Cost Centers	59,305	274,621	250,635	584,561		584,561	(121,219)	463,342			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,428,204	960,103	1,974,409	7,362,716		7,362,716	513,800	7,876,516			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(20,482)	2		4
5 Telephone, TV & Radio in Resident Rooms	(2,721)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	15,409	30		9
10 Interest and Other Investment Income	(2,780)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(25)	21		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(75,717)	43		24
25 Fund Raising, Advertising and Promotional	(13,562)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(4,230)	21		28
29 Other-Attach Schedule See Schedule 5a attached	(30,331)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (134,439)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	648,239		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 648,239		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 513,800		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Knox County Nursing Home

Provider #: 0010561

12/01/03 to 11/30/04

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Non-allowable farm expenses	(28,047)	43
Offset beauty shop income	(1,172)	40
Non-allowable radiology	(1,112)	10
Total	<u><u>(30,331)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Knox County Nursing Home

ID# 0010561

Report Period Beginning: 12/01/03

Ending: 11/30/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/03

Ending:

11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(20,482)	0	0	0	0	0	0	0	0	0	0	(20,482)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,482)	0	0	0	0	0	0	0	0	0	0	(20,482)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(4,255)	19,113	0	0	0	0	0	0	0	0	0	14,858	21
22	Employee Benefits & Payroll Taxes	0	629,126	0	0	0	0	0	0	0	0	0	629,126	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,255)	648,239	0	0	0	0	0	0	0	0	0	643,984	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,737)	648,239	0	0	0	0	0	0	0	0	0	623,502	29

Summary B

11/30/04

[illegible]

Facility Name & ID Number Knox County Nursing Home# 0010561

Report Period Beginning:

12/01/03

Ending:

11/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Knox County</u>		<u>N/A</u>		<u>N/A</u>		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	<u>Bookkeeping & accounting</u>	\$	<u>Knox County</u>	<u>100.00%</u>	\$ <u>19,113</u>	\$ <u>19,113</u>	1
2	V	22	<u>Employee benefits - IMRF</u>		<u>Knox County</u>	<u>100.00%</u>	<u>261,428</u>	<u>261,428</u>	2
3	V	22	<u>Employee benefits - FICA</u>		<u>Knox County</u>	<u>100.00%</u>	<u>367,698</u>	<u>367,698</u>	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ <u>648,239</u>	\$ * <u>648,239</u>	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/03 Ending: 11/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sally Keener	Board member	Administrative	0.00	0			Per diem &	\$ 385	L18, C3	1
2	Dale Parsons	Board member	Administrative	0.00	0			Mileage	420	L18, C3	2
3	Bill Abel	Board member	Administrative	0.00	0				420	L18, C3	3
4	Lowell Mannhardt	Board member	Administrative	0.00	0				420	L18, C3	4
5	Gayle Keiser	Board member	Administrative	0.00	0				420	L18, C3	5
6											6
7											7
8	Note - no member of the County Board provided direct services to the nursing home. In addition, no Board member has ownership in an entity that										8
9	conducted business transactions with the nursing home during the reporting period.										9
10											10
11											11
12											12
13								TOTAL	\$ 2,065		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home# 0010561

Report Period Beginning:

12/01/03Ending: 11/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Knox CountyStreet Address 200 South Cherry StreetCity / State / Zip Code Galesburg, IL 61401Phone Number (309) 345-3837Fax Number (309) 343-7002

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Booeekkping & accounting	Hours Worked	1,716	\$ 19,113	\$	1,716	\$ 19,113	1
2	22	Employee benefits - IMRF	Direct cost	1				261,428	2
3	22	Employee benefits - FICA	Direct cost	1				367,698	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 19,113	\$		\$ 648,239	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Greatamerica Leasing Corp		x	Purchase of computer equip	\$855.46	3/2003	\$ 23,351	\$ 13,159	3/2006	0.1708	\$ 2,660	1
2	Office Specialists Inc		x	Purchase of photocopier	\$243.41	9/2004	12,678	12,311	9/2009	0.0571	120	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$1,098.87		\$ 36,029	\$ 25,470			\$ 2,780	9
	B. Non-Facility Related*											
10								Offset interest income			(2,780)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			(2,780)	14
15	TOTALS (line 9+line14)						\$ 36,029	\$ 25,470				15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Knox County Nursing Home**# **0010561**Report Period Beginning: **12/01/03**

Ending:

11/30/04**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2003 report.		\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	\$ N/A	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td>8</td></tr> <tr><td>2000</td><td>9</td></tr> <tr><td>2001</td><td>10</td></tr> <tr><td>2002</td><td>11</td></tr> <tr><td>2003</td><td>12</td></tr> </table>	1999	8	2000	9	2001	10	2002	11	2003	12	<table border="1"> <tr> <td></td> <td>FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2003 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2003 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1999	8																											
2000	9																											
2001	10																											
2002	11																											
2003	12																											
	FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2003 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										
County home does not pay real estate taxes.																												

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Knox County Nursing Home COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0010561

CONTACT PERSON REGARDING THIS REPORT Marianne Wisen, Administrator

TELEPHONE (309) 289-2338 FAX #: (309) 289-8384

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u>County home does not</u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u>pay real estate taxes.</u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

100,375

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

One

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing home	1,481,040	1966	\$ 156,600	1
2					2
3	TOTALS	1,481,040		\$ 156,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/03

Ending:

11/30/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	204	1966	1966	\$ 1,842,192	\$ 36,844	50	\$ 36,844	\$	\$ 1,409,360
5									
6									
7									
8									
Improvement Type**									
9	1966 Land Improvements	1966		46,724	934	50	934		34,921
10	1971 Additions	1971		152,822		20			152,822
11	1980 Additions	1980		15,242		20			15,242
12	1981 Additions	1981		650		20			650
13	1983 Additions	1983		14,762		20			14,762
14	1984 Additions	1984		31,009	771	20	771		29,233
15	1985 Additions	1985		106,261	4,078	20	4,078		105,750
16	1986 Additions	1986		141,506		20			141,506
17	1987 Additions	1987		143,424		15			143,424
18	1988 Additions	1988		69,882	3,017	20	3,017		52,009
19	1989 Additions	1989		37,676	2,380	15	2,380		36,417
20	1990 Additions	1990		29,117	1,287	20	1,287		18,527
21	1991 Additions	1991		175,965	11,439	15	11,439		155,705
22	1992 Additions	1992		232,540	15,334	15	15,334		191,638
23	1993 Additions	1993		43,687	3,091	15	3,091		39,565
24	1994 Additions	1994		115,370	7,700	15	7,700		84,082
25	1995 Additions	1995		68,274	4,618	15	4,618		54,367
26	1996 Additions	1996		82,777	5,378	15	5,378		52,850
27	1997 Additions	1997		37,834	3,408	15	3,408		25,426
28	Bed Lights	1998		3,524	352	10	352		2,407
29	Parts for call system	1998		450	45	10	45		270
30	Fish Pond	1998		2,629	175	15	175		1,138
31	Garage Door	1998		1,110	74	15	74		493
32	Door alarm equipment	1998		596	60	10	60		399
33	Fire eye controls	1998		1,110	74	15	74		493
34	Fire eye controls	1998		545	36	15	36		235
35	Chiller Improvements	1998		1,503	100	15	100		1,461
36		1998		5,217	348	15	348		2,116

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/03

Ending:

11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Oil pump for compressor	1998	\$ 676	\$ 45	15	\$ 45	\$	\$ 672		37
38	New pumps	1998	1,298	85	15	85		1,298		38
39	Boiler improvements	1998	3,195	215	15	215		1,280		39
40	Boiler repairs	1998	475	32	15	32		212		40
41	Install fire eye	1998	182	12	15	12		80		41
42	Hot water storage tank	1998	11,904	595	20	595		3,719		42
43	Plumbing upgrades	1998	4,286	214	20	214		1,321		43
44	Compressor improvement	1998	1,333	89	15	89		548		44
45	Coil replacement	1998	1,048	70	15	70		431		45
46	Laundry room ventilation	1999	3,246	216	15	216		1,396		46
47	Steam generated tanks	1999	13,865	924	15	924		5,968		47
48	Pump	1999	924	92	10	92		2,911		48
49	Air conditioner	1999	2,476	248	10	248		1,239		49
50	Freezer compressor	2000	2,321	232	10	232		1,122		50
51	Air conditioner	2000	2,810	281	10	281		1,194		51
52	Exhaust Fan	2000	1,500	150	10	150		613		52
53	Hot water heater	2000	13,865	1,387	10	1,387		6,934		53
54	Fireplace	2001	1,395	140	10	140		432		54
55										55
56	Architect fees - Boiler work	2003	11,412	571	20	571		856		56
57	Boiler replacement & upgrade	2003	80,229	4,011	20	4,011		6,017		57
58	Asbestos inspections	2003	9,825	491	20	491		766		58
59	Architect - Toilet & bathing rooms	2003	1,916	96	20	96		150		59
60	Framing, drywall, plumbing, finishing - Handicap bathrooms	2003	26,549	1,327	20	1,327		2,070		60
61	Bathroom fixtures, hand rails	2003	3,819	382	10	382		573		61
62	Tub	2003	3,895	390	10	390		585		62
63	Architect - Hospice wing	2003	4,480	224	20	224		336		63
64										64
65	Hospice - Minor renovation, drywall, wall coverings	2003	8,182	409	20	409		614		65
66	Wall coverings, drywall, minor renovation	2003	10,264	513	20	513		770		66
67	Garden room doors	2003	1,691	85	20	85		127		67
68	Unreconciled difference							(2,450)		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,633,459	\$ 115,069		\$ 115,069	\$	\$ 2,809,052		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

11/30/04

****Improvement type must be detailed in order for the cost report to be considered complete**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 577,343	\$ 44,287	\$ 44,287	\$	5-10	\$ 264,712	71
72	Current Year Purchases	96,261	4,813	4,813		10	4,813	72
73	Fully Depreciated Assets	327,648					327,648	73
74								74
75	TOTALS	\$ 1,001,252	\$ 49,100	\$ 49,100	\$		\$ 597,173	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	Van	1992	\$ 38,295	\$	\$	\$	4	\$ 38,295	76
77	Resident care	Ford Escort Wagon	1993	10,827				4	10,827	77
78	Resident care	Ford Truck	1995	17,024				4	17,024	78
79										79
80	TOTALS			\$ 66,146	\$	\$	\$		\$ 66,146	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,931,805	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,609	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 166,609	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,474,811	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				<u>N/A</u>			4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 2,911 Description: Dishwasher - \$ 2,309; Pagers - \$ 602

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$

13. /2006 \$

14. /2007 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			<u>N/A</u>		19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,121	\$ 37,863	\$	1,121	\$ 37,863	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		471	21,659		471	21,659	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,497	55,430		1,497	55,430	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				262,751		262,751	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	L39, C1, C2, C3	1312	40,921	274	9,866	10,698	1,586	61,485	12
13	Other (specify):									13
14	TOTAL			\$ 40,921	3,363	\$ 124,818	\$ 273,449	4,675	\$ 439,188	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Knox County Nursing Home

Provider #: 0010561

12/01/03 to 11/30/04

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/03

Ending:

11/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 974,233	\$ 974,233	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance none)	1,583,674	1,583,674	3
4	Supply Inventory (priced at)	38,710	38,710	4
5	Short-Term Investments			5
6	Prepaid Insurance	6,608	6,608	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,603,225	\$ 2,603,225	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	44,801	44,801	12
13	Land	156,600	156,600	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,620,545	3,707,807	15
16	Equipment, at Historical Cost	1,007,107	1,067,398	16
17	Accumulated Depreciation (book methods)	(3,402,840)	(3,474,811)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,426,213	\$ 1,501,795	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,029,438	\$ 4,105,020	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 148,095	\$ 148,095	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	222,311	222,311	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached Schedule 17C</u>	114,890	114,890	36
37	<u>Accrued assessment fee</u>	18,768	18,768	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 504,064	\$ 504,064	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,470	25,470	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 25,470	\$ 25,470	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 529,534	\$ 529,534	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,499,904	\$ 3,575,486	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,029,438	\$ 4,105,020	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Knox County Nursing Home
PROVIDER # 0010561
11/30/2004

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Current Liabilities

		After
Other Current Liabilities (specify):	Operating	Consolidation
Due to thrid party payor	102,544	102,544
Due to resident trust funds	12,346	12,346
Total Line 36 - Other Current Liabilities(specify):	114,890	114,890

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,169,462	1
2	Restatements (describe):		2
3			3
4	Adjustments subsequent to prior year cost report	244,437	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,413,899	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	86,005	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 86,005	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,499,904	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,536,308	1
2	Discounts and Allowances for all Levels	(237,638)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,298,670	3
B. Ancillary Revenue			
4	Day Care	16,870	4
5	Other Care for Outpatients		5
6	Therapy	60,977	6
7	Oxygen	45,600	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 123,447	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	20,482	12
13	Barber and Beauty Care	5,767	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	224,150	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	138,494	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 388,893	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,460	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,460	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Farm income, net of expenses	12,245	28
28a	Tax referendum receipts	616,006	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 628,251	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,448,721	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,775,679	31
32	Health Care	3,706,657	32
33	General Administration	1,138,928	33
B. Capital Expense			
34	Ownership	156,891	34
C. Ancillary Expense			
35	Special Cost Centers	472,673	35
36	Provider Participation Fee	111,888	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,362,716	40
41	Income before Income Taxes (line 30 minus line 40)**	86,005	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 86,005	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Knox County Nursing Home**# **0010561**Report Period Beginning: **12/01/03**Ending: **11/30/04****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 56,248	\$ 27.04	1
2	Assistant Director of Nursing	2,080	2,080	54,188	26.05	2
3	Registered Nurses	15,661	15,661	318,540	20.34	3
4	Licensed Practical Nurses	41,533	41,533	727,148	17.51	4
5	Nurse Aides & Orderlies	130,683	130,683	1,801,139	13.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	30,005	14.43	9
10	Activity Assistants	6,653	6,653	65,645	9.87	10
11	Social Service Workers	11,308	11,308	153,115	13.54	11
12	Dietician					12
13	Food Service Supervisor	1,325	1,325	40,335	30.44	13
14	Head Cook	11,202	11,202	124,028	11.07	14
15	Cook Helpers/Assistants	19,183	19,183	213,805	11.15	15
16	Dishwashers					16
17	Maintenance Workers	7,619	7,619	125,587	16.48	17
18	Housekeepers	19,894	19,894	218,651	10.99	18
19	Laundry	6,651	6,651	69,248	10.41	19
20	Administrator	1,733	1,733	91,177	52.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,380	11,380	159,393	14.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,535	1,535	18,308	11.93	31
32	Other Health Care See Sch 20A	8,909	8,909	143,260	16.08	32
33	Other(specify) Beauty shop	1,833	1,833	18,384	10.03	33
34	TOTAL (lines 1 - 33)	303,342	303,342	\$ 4,428,204 *	\$ 14.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	176	\$ 8,190	L1, C3	35
36	Medical Director	Monthly	12,500	L9, C3	36
37	Medical Records Consultant	Monthly	1,850	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	11,792	L10, C3	39
40	Physical Therapy Consultant	108	5,320	L10A, C3	40
41	Occupational Therapy Consultant	36	1,676	L10A, C3	41
42	Respiratory Therapy Consultant	10	712	L10A, C3	42
43	Speech Therapy Consultant	5	292	L10A, C3	43
44	Activity Consultant	43	2,353	L11, C3	44
45	Social Service Consultant	42	2,352	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	468	\$ 47,037		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	None	N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Knox County Nursing Home
PROVIDER # 0010561
November 30, 2004

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (specify)

	Hours Worked	Hours Paid	Salary	Avg Hr Wage
Care Plan Coordinator	3,809	3,809	\$ 39,517	\$ 10.37
Medicare Coordinator	2,080	2,080	44,389	21.34
Exceptional Care Nursing	1,312	1,312	40,921	31.19
Transportation	1,708	1,708	18,433	10.79
<hr/>				
Total Line 32 - Other	8,909	8,909	\$ 143,260	\$ 16.08

See Accountants' Compilation Report

Knox County Nursing Home

Provider #: 0010561

12/01/03 to 11/30/04

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 0

Allocated from Management Company

Total (agree to Schedule V, line 19, column 8) 0

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

Amount of Expense Amortized Per Year													
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - 11,016; IL County NH Assn - 1,750
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,645 Line L10, C2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 111,888
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 13,048 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Blucker, Kneer & Assoc. Ltd The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service: performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	378,168	33,571	8,190	419,929	0	419,929	0	419,929
2. Food Purchase	0	376,377	0	376,377	0	376,377	-33,530	342,847
3. Housekeeping	218,651	39,774	0	258,425	0	258,425	0	258,425
4. Laundry	69,248	15,933	117,024	202,205	0	202,205	0	202,205
5. Heat and Other Utilities	0	0	212,584	212,584	0	212,584	0	212,584
6. Maintenance	125,587	49	180,523	306,159	0	306,159	0	306,159
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	791,654	465,704	518,321	1,775,679	0	1,775,679	-33,530	1,742,149
9. Medical Director	0	0	12,500	12,500	0	12,500	0	12,500
10. Nursing & Medical Records	3,059,477	199,784	31,754	3,291,015	0	3,291,015	-1,112	3,289,903
10a. Therapy	0	0	122,952	122,952	0	122,952	0	122,952
11. Activities	95,650	6,791	2,353	104,794	0	104,794	0	104,794
12. Social Services	153,115	1,496	2,352	156,963	0	156,963	0	156,963
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	18,433	0	0	18,433	0	18,433	0	18,433
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,326,675	208,071	171,911	3,706,657	0	3,706,657	-1,112	3,705,545
17. Administrative	91,177	0	10,200	101,377	0	101,377	0	101,377
18. Directors Fees	0	0	2,065	2,065	0	2,065	0	2,065
19. Professional Services	0	0	35,692	35,692	0	35,692	0	35,692
20. Fees, Subscriptions & Promotion	0	0	21,232	21,232	0	21,232	0	21,232
21. Clerical & General Office	159,393	11,707	26,648	197,748	0	197,748	14,858	212,606
22. Employee Benefits & Payroll	0	0	754,976	754,976	0	754,976	642,174	1,397,150
23. Inservice Training & Education	0	0	4,862	4,862	0	4,862	0	4,862
24. Travel and Seminar	0	0	1,454	1,454	0	1,454	0	1,454
25. Other Admin. Staff Trans	0	0	7,166	7,166	0	7,166	0	7,166
26. Insurance-Prop.Liab.Malpractice	0	0	12,356	12,356	0	12,356	0	12,356
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	250,570	11,707	876,651	1,138,928	0	1,138,928	657,032	1,795,960
29. Total General Administrative	4,368,899	685,482	1,566,883	6,621,264	0	6,621,264	622,390	7,243,654
30. Depreciation	0	0	151,200	151,200	0	151,200	15,409	166,609
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	2,780	2,780	0	2,780	-2,780	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	2,911	2,911	0	2,911	0	2,911
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	156,891	156,891	0	156,891	12,629	169,520
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	40,921	273,449	9,866	324,236	0	324,236	0	324,236
40. Barber and Beauty Shop	18,384	1,172	0	19,556	0	19,556	-1,172	18,384
41. Coffee and Gift Shops	0	0	8,834	8,834	0	8,834	0	8,834
42	0	0	111,888	111,888	0	111,888	0	111,888
43. Other (specify):*	0	0	120,047	120,047	0	120,047	-120,047	0
44. Total Special Cost Ce	59,305	274,621	250,635	584,561	0	584,561	-121,219	463,342
45. Grand Total	4,428,204	960,103	1,974,409	7,362,716	0	7,362,716	513,800	7,876,516

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	974,233	974,233
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,583,674	1,583,674
4. Supply Inventory	38,710	38,710
5. Short-Term Investments	0	0
6. Prepaid Insurance	6,608	6,608
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,603,225	2,603,225
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	44,801	44,801
13. Land	0	0
14. Buildings, at Historical Cost	0	0
15. Leasehold Improvements, Historical Cost	4,784,252	4,931,805
16. Equipment, at Historical Cost	0	0
17. Accumulated Depreciation (book methods)	-3,402,840	-3,474,811
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,426,213	1,501,795
25. Total Assets	4,029,438	4,105,020
CURRENT LIABILITIES		
26. Accounts Payable	148,095	148,095
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	222,311	222,311
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	114,890	114,890
37. Other Current Liabilities (specify):	18,768	18,768
38. Total Current Liabilities	504,064	504,064
LONG TERM LIABILITES		
39.Long-Term Notes Payable	25,470	25,470
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	25,470	25,470
46.Total Liabilities	529,534	529,534
47.Total Equity	3,499,904	3,575,486
48.Total Liabilities and Equity	4,029,438	4,105,020

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,536,308
2. Discounts and Allowances for all Levels	-237,638
Subtotal - Inpatient Care	6,298,670
4. Day Care	16,870
5. Other Care for Outpatients	0
6. Therapy	60,977
7. Oxygen	45,600
Subtotal - Ancillary Revenue	123,447
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	20,482
13. Barber and Beauty Care	5,767
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	224,150
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	138,494
22. Laundry	0
Subtotal - Other Operating Revenue	388,893
24. Contributions	0
25. Interest and Other Investments Income	9,460
Subtotal - Non-Operating Revenue	9,460
27. Other Revenue (specify):	12,245
28. Other Revenue (specify):	616,006
Subtotal - Other Revenue	628,251
30. Total Revenue	7,448,721
31. General Services	1,775,679
32. Health Care	3,706,657
33. General Administration	1,138,928
34. Ownership	156,891
35. Special Cost Centers	472,673
35. Provider Participation Fee	111,888
37. Other	0
40. Total Expenses	7,362,716
41. Income Before Income Taxes	86,005
42. Income Taxes	0
43. Net Income or Loss for the Year	86,005

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